0.009). Adjusted for community antibiotic prescribing, the hospital costs of patients with LRTI were significantly higher than those of patients with COAD ($p = 0.001$) but not those of patients with COAD+LRTI ($p = 0.096$).
CONCLUSION: Economic models of the potential impact of different community antibiotics on hospital LRTI costs will be subject to case mix bias unless they adjust for community antibiotic use and co-morbidity with COAD.

PIC11

A HEALTH ECONOMIC EVALUATION OF PACLITAXEL AND CARBOPLATIN VERSUS VINORELBINE AND CISPLATIN COMBINATION CHEMOTHERAPY IN THE TREATMENT OF ADVANCED NON-SMALL CELL LUNG CANCER

Sinha N[1], Hainsworth JD[2], Einarson TR[3], Doyle JJ[1], Arikian SR[1], Lappas PT[1]
[1]Center for Health Outcomes and Economics, A Division of Bristol-Myers Squibb Company, East Brunswick, NJ, USA; [2]Sarah Cannon Cancer Center, Nashville, TN, USA; [3]University of Toronto, Toronto, Canada

The platinum chemotherapeutic compounds (cisplatin and carboplatin) are widely used in the treatment of advanced Non-Small Cell Lung Cancer (NSCLC). The introduction of new agents such as paclitaxel and vinorelbine has resulted in the development of combination regimens with improved response rates and survival. Two commonly used regimens, paclitaxel/carboplatin (TP) and vinorelbine/cisplatin (NP), are compared in this pharmacoeconomic analysis.
METHODS: A meta-analysis of available clinical trials was conducted to estimate the clinical effectiveness of TP and NP. Literature and physician interviews provided information on resource utilization and adverse event management (AEM) for these regimens. Treatment models were populated with Medicare reimbursement figures to compare the expected cost of treatment.
RESULTS: The expected cost of the TP and NP regimens was $19,322 and $20,790, respectively. Although the efficacy of these regimens has not been compared in a randomized trial, meta-analysis of regimented phase II and III studies showed no statistically significant differences in response rates. Therefore, equivalent efficacy is assumed in this cost comparison. A 20% variation in the cost of underlying resources yielded a 7% standard deviation in results. This sensitivity analysis showed that the costs of these regimens are insensitive to variations in underlying parameters.
CONCLUSION: This study suggests that TP is the pharmacoeconomic NSCLC treatment of choice when compared to NP. The analysis reveals that low administration and AEM costs are the key drivers in the lower treatment cost of TP.